UNM Sandoval Regional Medical Center, Inc.

Patient Name:
DOB:
MRN:

Sleep Clinic, 3001 Broadmoor Blvd. NE, Rio Rancho, NM 87144
Scheduling: (505) 994-7397 **Fax**: (505) 994-7495

External Referral / Consult Request Form

Instruction: The following information will be required for review of your referral. Please submit complete packet to the fax number above and allow up to 8 days for review.

- **Patient Demographics & Insurance Information** ☐
  - Please include patient name, address, best contact number, insurance name & policy number
- **Contact information for PCP <u>and/or</u> referring physician** ☐
  - Please include address, phone and fax number
- **Consult Request / Referral** ☐
  - What question do you need addressed by the specialist?
- **Recent Clinic/Progress Notes** ☐
  - Last visit, including what treatments have been done for the condition or problem
- **Recent Diagnostic Reports** (up to 3 months) ☐
  - Laboratory: TSH level, etc.
  - Other: Sleep studies, Titration study / levels, CPAP download data
  - Bring all CPAP equipment for eval at visit (face mask etc) *Not machine*
- **Current Medication List** ☐
- **Urgent consultation via phone**. Please call (888) UNM –PALS to discuss this referral

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Patient Appointment Status – For SRMC Clinic Use Only

☐ Appointment has been made with Dr. _____on _____ at _____am/pm

☐ Not able to schedule appointment due to:

__ Incomplete information for referral review
Comments:

__ Unable to contact patient
__ Patient declined appointment
__ Recommend appointment with the following specialty _____.

We have forwarded your referral to the above at: _____ .

Clinical Reviewer Signature: _____ Date: _____ Doc in EHR: Y / N